

**VIII. The Therapy of Club-Foot in the Clinic at Heidelberg During the Last Decade.** By DR. GUSTAV KRAUSS (Darmstadt).—Professor Czerny teaches that in pes varus the orthopædic methods surpass in their results the operative treatment (resection). In the former the elastic walk remains to the patient, whereas resection gives a stiff gait. The talus extirpation corrects only the apparent deformity, while the apparatus is more far reaching and helps to correct the false position of the different parts of the skeleton involved by the club-foot deformity. According to Professor Czerny, the orthopædic treatment of club-foot up to the fourth year of life yields better results than the operative methods. In the adult the choice between orthopædic and operative measures is more in favor of the latter. If a return of symptoms occurs in those treated by the orthopædic measures, the patients may be treated again in the same manner as at first. Return of symptoms in operative cases demand generally an operative procedure followed by orthopædic treatment. Cases must be individualized, but in general the rule is to try all orthopædic means before resorting to operation. The social position of the patient may prevent the undertaking of a long course of treatment. Here we will naturally be operative in idea. In the clinic of Heidelberg the congenital club-foot is put under treatment two or three weeks after birth (Brückner's method). Massage, redressment, taping are used in slight cases of pes varus. The children are manipulated twice a day under observation until redressment is effected; they are then seen once a month. Massage in a marked degree increases muscular tonicity of these little patients. Tenotomies of the tendo Achilles, fascia plantaris and tibialis posticus occur most frequently. The plaster splint is best applied with necessary redressment in small children with chloroform narcosis. Splint remains 14 days, followed in slight cases by massage and apparatus. After tenotomy and redressement Scarpa's shoe is worn during the day, and Czerny's splint at night. The external splint at first should have an angle of 90° to the foot piece. Prof. Czerny holds that cure shall be evidenced by the patient's ability to stand himself on his toes and to crouch down while the plantar surfaces are well set on the ground without falling. In or-

der to develop the muscles of the calf of the legs, Prof. Czerny directs patients to continually exercise the position of standing on the toes and to take a crouching position while the plantar surfaces of the feet are in contact with the ground. Author follows with tables of patients treated in the clinic for club-foot. The percentage of club-foot to all other surgical diseases was, during the past ten years, 0.46 %. The occurrence of congenital forms of club-foot to other forms is 78% to 81%; paralytic, 18.4%; traumatic club-foot occurs 1.4% of all cases of club-foot. In congenital double club-foot the right side was more markedly deformed in 13 cases of 23. Author cites only 3 cases of the Heidelberg clinic (137 cases) where heredity of club-foot was traced through some member of family. Among 137 cases of club-foot, the following anatomical anomalies were found: Torticollis (1), chronic hydrocephalus (1), manus valga (3), athetosis (1), simpliciosis (3), double six fingers (1), umbilical hernia (1), absence of a toe, etc. (1), progressive atrophic paralysis (3).

In 3 congenital cases subsequent scoliosis developed. Though the congenital cases are put under treatment as soon as possible, most cases are not seen until after the third month, 54+%. Among 126 cases of club-foot 13 were treated after operative methods; in these cases the results would have been more satisfactory had an orthopædic treatment been adopted.—*Deutsch Zeitsch. f. Chir.*, bd. 28 heft, 4 and 5.

HENRY KOPLIK, (New York).

**IX. A Case of Rachitis Adolescentium.** By C. B. KEETLEY, F.R.S.C. (London). Emily R. æt. 20 years, about eight years (?) ago noticed marked swelling of the right hip, diagnosis varying between dislocation, periostitis and tumor. Nothing was done for the case, and no improvement taking place she was brought under Mr. Keetley's care who after careful observation, diagnosed rachitis adolescentium (from the slow progress of the affection and the sudden development of a superadded scoliosis) attacking first the upper epiphyseal region of the right femur, and after some years the epiphyseal regions of the vertebræ. The scoliosis was not due to the apparent